Editorials

How Can Organized Medicine Ever Do All the Things It Ought to Do?

EVERYONE HAS IDEAS about what the medical profession and organized medicine ought to be doing at this perplexing moment in the history of health care in this nation. Some might want to declare victory and say that all of today's health care problems are simply the problems of success of a system that brought better health care to more people than at any other time in history. This is true, but it doesn't solve many of the problems we have today. The clock moves forward, and it is the side effects and complications of this unprecedented medical and social achievement that are becoming evident, and with which both medicine and society must try to learn to cope. It is also becoming clear that many of the things that have to be dealt with are all going on at once. None of them can be ignored for long except at some peril. The intensity of these concurrent urgencies seems to be something new. Our accustomed way of doing things, which is to apply our energies and resources to what seem to be the highest priorities at a given moment, is inadequate to deal effectively with this new problem of so many high priority concerns that all need to be dealt with at the same time.

Almost every physician and just about every medical society knows what these concerns are. Each seems to take the form of a crisis, and each new crisis seems to pile on top of all the others before any of them are really solved. We have a malpractice crisis; we have never-ending legislative crises; problems in financing the cost of patient care and medical education; a host of governmental and third party interventions in health care; ethical problems and adversary relationships developing between hospitals and physicians as a result of the element of competition that has recently been introduced into health care, and more recently what appears to be a lessening public approval of the performance of the medical profession as a whole, although a person's own physician still seems to be held in relatively high esteem. And even these are only some of the more pressing problems facing the medical profession. All in all, it is little wonder that physicians are turning to their medical associations for guidance—and solutions. The physician membership in organized medicine may ask if the medical profession can ever hope to deal effectively with all these concurrent problems. Will it ever be possible to do all the things the profession ought to do? It just may be that frustration about this, as well as the ever increasing cost of membership in medical associations, may contribute to the slippages in membership retention that many associations are beginning to experience.

But need this be so? How might organized medicine begin to deal more effectively with all these concurrent and complex problems that are the side effects and complications resulting from a superb medical and social achievement? A good start has been made. The medical profession and organized medicine have not panicked, but remain steadfast in the belief that a physician's first responsibility is to his or her patients and to no one else, and to something called quality of care and, of course, to containing costs as much as possible. But something more will be needed than simply reaffirming principle and reacting piecemeal to crisis piled upon crisis. It will require the marshaling of the special knowledge and skills of the profession and bringing them to bear, not only in the patients' interest but also on the quality and cost of care, on the promotion of health and in the public's interest. The real strength—and power—of the medical profession lies in its special knowledge, skills and expertise and how effectively these are applied in all aspects of health care, including its social, economic and political aspects.

Looked upon in this way, the list of things the medical profession "ought to do" seems virtually limitless. Many specifics have been repeatedly suggested in professional periodicals and in the public communications media. For example, it has been said that only the medical profession has the skill and expertise to identify and eliminate worthless treatments, reduce the iactogenic injuries and disease that sometimes accompany modern diagnosis and treatment, or provide the information needed to correct indefensible variations in the cost of caring for the same conditions with the same results in different locations. It has been suggested that physicians aggressively seek to participate, that the profession bring its knowledge, skills and expertise to bear in the decision-making process at every level of health care, and so begin to counteract the trend to place medical decision making in other hands. Some more specific suggestions that have appeared in this journal include the following: develop computerized patient care data bases so as to measure quality as well as cost of care rendered; explore the concept of "generic" medicine and surgery; promote a problem-solving protocol for the broader problems in health care based on the proved problem-solving techniques a physician uses in a difficult or complex case; develop improved physicians' communication skills with patients and the public; organize patients and their relatives and interested persons in a community into pressure groups to support physicians' efforts in behalf of patients and better patient care.

But the basic problem remains. To do the many things it is said that organized medicine "ought to do," a very large number of things will need to be done at the same time. Perhaps a way to do it is to divide the responsibilities among the many associations in such a fashion that each would be able to contribute a part to the whole of what it is agreed "ought to be done," each in accordance with its own interests, commitment and resources. There are 50 state medical associations and probably hundreds of more-or-less sophisticated county medical societies that could participate, not to mention the specialty societies. If there were some kind of a

master framework to coordinate study and action throughout the profession, then an organizational instrument might be created that could in fact bring the special knowledge and expertise of the medical profession effectively to bear, simultaneously, on so many of the things organized medicine ought to be doing with so many of the presently unstudied and unsolved problems in health care.

MSMW

Screening for Disabilities

ELSEWHERE IN THIS ISSUE Foster and colleagues have provided an excellent description of the activities that physicians should use in their efforts to prevent disabilities or to identify existing disabilities as early as possible. We know why such efforts are important from a medical standpoint. When we cannot actually prevent disabilities, time is of the essence in our efforts to contain and compensate for the effects of a given disability and to hold unnecessary involvement to a minimum.

Where we often fail in medicine, I believe, is in considering the total impact of a disability on the life functioning of our patients. Because our perspective is too physiological, we sometimes miss opportunities to have our medical interventions contribute to improved functioning for the individual person in the world at large. If our choice of medical intervention could be based not only on consideration for the medical condition but also on consideration for keeping a child in school or maintaining a young adult in a vocational program, our patients' well-being would be better served.

Disabilities can affect all aspects of a person's life—educational, employment and social—not just those bracketed off as "health" concerns. Serving patients with disabilities calls for a broad awareness of the nature of disabling conditions in this country and of the service system that is involved with persons with disabilities. For a physician working with disabled patients, this awareness requires the following:

- A knowledge of the facts about disabling conditions. What are the nature and size of the population of persons with disabilities? When are these conditions most likely to occur? How can we be alert to vulnerable periods?
- A knowledge of the resources available for persons with disabilities, locally and in federal and state programs, so that working relationships can be established with the professionals who are or should be involved with a patient at the same time the physician addresses medical needs.

The Population

From 1% to 2% of all newborns have discernible disabilities or developmental defects. This includes visibly obvious structural anomalies such as spina bifida, congenital heart defects that require more subtle examination techniques for detection and problems discovered via biochemical analysis, such as phenylketonuria. Also included are infants having intracranial hemorrhages, respiratory problems requiring ventilation or severe infections occurring during the neonatal period.

Approximately 10% of all children enrolled in this nation's schools are eligible for special education or "related services" under Public Law 94-142, the Education of All Handicapped Children Act of 1975. This includes those with disabling conditions and other developmental problems that interfere with the *education* of a child, including such conditions as relatively mild, transient speech-articulation defects. We seem to be doing well at identifying sensory, cognitive, intellectual or learning problems that directly affect the educational needs of a child, but sometimes children with physiologic disease, motor disorders or emotional problems are less well identified by the education system because the problem does not directly affect the child's educational process.

Approximately 15% of the adults between 18 and 65 years of age in this country are considered disabled to the extent that they do not participate in regular employment. This includes persons affected by severe disabling conditions such as quadriplegia or mental retardation, chronic lower back disabilities, mental illness and those who are malingering.

Approximately 1% of the persons in this country, including some members of the previously described populations, have sensory, cognitive, motor, physiologic or mental health disorders that were manifest before age 22 years and that significantly affect their functional lives. They are known as persons with *developmental disabilities* according to Public Law 98-527, the Developmental Disabilities Act of 1984.

The percentage of persons with developmental disabilities remains fairly constant, both relatively and absolutely. Advances in medical and surgical treatments (such as cardiac surgery) permit a limited number of disabled persons to achieve fully functional lives. Some achieve independence through bioscientific achievements, such as out-of-hospital ventilatory assistance, and others through evolving positive societal attitudes, such as employment opportunities for those with significant retardation. It appears that accidents, degenerative diseases that do not manifest until the teenage years and complications of disease such as arthritis, diabetes and other medical conditions are the principal reasons for additions to the disabled population that cause the rate to remain essentially at 1% of the nation's population over time.

Genetic defects, including chromosomal aberrations, and prenatal environmental causes constitute a large percentage of developmental problems. The majority of prenatal causes remains unknown. At the present time, prenatal identification of such genetic and environmental causes exists for a meaningful but yet small percentage of those who will eventually manifest developmental disabilities. Perinatal causes, especially hypoxia, anoxia and infections, account for a large proportion of all developmental disorders.

An important segment of the developmentally disabled population is made up of children known to have renal disease, cardiomyopathies, muscular disorders, mental illness and other disorders that worsen over time and eventually significantly affect physical and cognitive functions. Knowledgeable physicians and other health professionals initiate screening procedures in their practices to identify their patients who show such signs and symptoms and coordinate or provide the required evaluation and referral services.

Physicians who care for adolescents and young adults often treat the residuals of vehicular accidents, attempted homicides, industrial and construction accidents, diving and other sports-related injuries typical of the fast-paced, action-oriented lives of this segment of our population. This patient cohort's need is not screening for identification, but periodic monitoring to ensure that needed services are available and that the young person is known to all the required educational,